STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING _____ B. WING _____	C 10/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CYPRESS GROVE REHABILITATION CENTER	**4255 MEDWELL DR NEWBURGH, IN 47630**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00155858. This visit was in conjunction with a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 8/27/14. Complaint Number: IN00155858 - Substantiated. No deficiencies related to the allegation cited. Survey Dates: 10/5/14, 10/7/14, 10/8/14, 10/9/14 Facility Number: 000173 Provider Number: 155273 AIM Number: 100290920 Survey Team: Barbara Fowler RN TC (10/7, 10/9/2014) Denise Schwandner RN (10/7, 10/8, 10/9/2014) Diana Perry RN (10/7, 10/8, 10/9/2014) Anna Villain RN Census Bed Type: SNF/NF: 70 Total: 70 Census Payor Type: Medicare: 5 Medicaid: 46 Other: 19 Total: 70 Sample: 18 Cypress Grove Rehabilitation Center was found to be in compliance with 42 CFR Part 483,	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155273	A. BUILDING _____ B. WING _____	C 10/09/2014

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F 000	Continued From page 1 Subpart B and 410 IAC 16.2-3.1 in regard to the Recertification and State Licensure Survey. Quality review completed on October 11, 2014, by Janelyn Kulik, RN.	F 000		